STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. Building B. Wing	10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Albert Lea	75507 240th Street Albert Lea, MN 56007

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to maintain the right to privacy and confidentiality for 1 of 4 residents (R1), reviewed for privacy and discreetness of medical information. Staff used personal cellular (cell) phones to photograph and share pictures of R1's foot wound, infested with maggots. Findings include: R1's quarterly minimum data set (MDS) assessment dated [DATE], indicated R1 was cognitively intact; however, R1 had early dementia. R1's care plan dated 8/8/18, indicated R1 had blisters on the top of her left foot which had occurred following left foot fractures. R1's face sheet dated 9/6/18, indicated R1 had [DIAGNOSES REDACTED]. R1 was receiving monthly [MEDICAL CONDITION] for a skin [MEDICAL CONDITION] and was immunosuppressed. R1's physician order [REDACTED]. On 8/4/18, registered nurse (RN)-L created an incident report for R1 noting, This nurse was notified by the aide that dressing on elder's left foot looks icky and that elder stated that her foot feels twitchy, however she denied pain when asked. And when this nurse opened the dressing to change it, there were so many maggots on the wound. The dressing was last changed on 8/2/18. The dressing is supposed to be changed daily in the morning. 'It feels twitchy and stingy.' A facility internal investigation document, dated 8/15/18 indicated licensed practical nurse (LPN)-H stated RN-L took pictures of R1's infested foot wound and sent them to LPN-H's phone for RN-E, a nurse manager. LPN-H showed RN-E the pictures the next day. LPN-H stated she knew it was wrong to take pictures but RN-E wanted to see them. LPN-H stated she would delete the photos. A facility internal investigation document dated 8/15/18, indicated RN-L acknowledged having pictures of R1's wound on her phone and stated RN-E told her to take them. RN-L admitted taking the picture of R1's wound and sending them to RN-E. RN-L stated she would normally never take a picture but RN-E had directed her to. RN-L stated she deleted the pictures the same day. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility Internal Investigation document dated 8/15/18, indicated RN-I heard about R1's foot wound while working at another job. According to the document, RN-I came to work over the weekend and LPN-H was present. LPN-H asked RN-I if she wanted to see a picture of R1's foot wound, and then took out her personal cell phone and showed RN-I a picture. An undated facility Internal Investigation document indicated RN-E had pictures of R1's wound on her personal cell phone when she came to the office to discuss the investigation. RN-E was asked to delete the pictures. During an interview on 9/6/18 at 1:54 p.m., LPN-A stated nursing assistant (NA)-F told her she overheard RN-I ask LPN-H to show her a picture of R1's foot wound with maggots. LPN-A also stated she'd heard RN-L had sent a picture to LPN-B, but she did not know how LPN-H obtained a picture. LPN-A said LPN-H told LPN-A she had deleted the photo after having showed RN-I the picture of R1's foot wound. LPN-A stated taking pictures of a resident's wound was a violation of resident privacy. During an interview on 9/6/18 at 3:12 p.m., R1 stated she saw lots of flashes from little cameras going off in her room before she was transferred to the hospital. R1 stated she was pretty popular for a while, and said she thought the nurses and aides took multiple photos. R1 was unable to recall whether anyone had asked for her consent. When interviewed on 9/6/18 at 4:34 p.m., LPN-B stated after staff discovered maggots on R1's foot wound, RN-E (nurse manager) told RN-L and LPN-B to take a picture of the wound and send it to her. LPN-B said initially RN-L gave her personal cell phone to NA-K to take the pictures however, LPN-B did not think it was a suitable role for NA-K. LPN-B took RN-L's phone and she and NA-K went to R1's room. LPN-B took multiple photos of the maggots, R1's wound, and the wound dressing. LPN-B stated afterwards she returned RN-L's phone, and RN-L sent the pictures to RN-E. LPN-B stated at the time she did not question taking photos of R1's wound because RN-E was her contact person for the weekend. However, at the time of the interview LPN-B acknowledged she should not have photographed R1's wound. LPN-B stated RN-L sent the pictures to her via a social media application, but LPN-B deleted them before the end of her shift. LPN-B stated she did not ask for the pictures and did not send them to anyone, but other staff came and asked to see the pictures because NA-K said LPN-B had them. LPN-B stated taking pictures of R1's wound was justified because a nurse manager asked for them. LPN-B stated the pictures should not have gone beyond the staff that needed to see them. LPN-B also stated a facility policy spoke to not taking pictures of residents. LPN-B also stated she did not think the picture sharing was malicious; rather, staff were interested in seeing the wound due to the rarity of the situation. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/7/18 at 9:46 a.m., the Director of Nursing (DON) stated she returned from being out of the office for a few days and heard there were pictures of R1's foot wound. The Director of Human Resources (DHR) headed the facility's investigation into the matter. The DON stated approximately a week later, NA-F told her that over the weekend LPN-H showed RN-I a picture of R1's wound. The DON said she spoke with the DHR and learned RN-E had asked RN-L to take a picture of R1's wound. The DON said during conversation with RN-I, RN-I told the DON she learned of the situation with R1's foot wound at another job, and during conversation LPN-H showed RN-I a picture of the wound. The DON stated LPN-H admitted having a picture of R1's wound on her personal cell phone but said she deleted it after showing the picture to RN-I. The DON stated the facility's policy is not to take pictures of residents, and certainly not on personal cell phones. The DON said the pictures violated the facility's policy. The DON stated there was no reason for any staff, including those directly involved in caring for R1 at the time of the incident, to photograph, store, or share pictures of R1's foot wound. The DON stated staffs' sharing pictures of R1's foot wound was a dignity and privacy issue for the resident. When interviewed on 9/11/18 at 5:05 p.m., RN-E stated RN-L called and asked when maggots were put on R1's foot wound, and RN-E said she'd reported they were not. RN-E stated RN-L offered to send her a picture, and RN-E agreed without thinking about it. RN-E said RN-L sent her two pictures of R1's foot wound infested with maggots. RN-E stated she'd recently learned LPN-B took the pictures, though RN-L sent them via text to RN-E's phone. RN-E knew that LPN-H had a picture, but did not know how she'd obtained it. RN-E stated a day or two after the incident she showed the DON a picture of R1's foot wound. RN-E stated the DON did not say anything and did not advise her to delete the pictures from her phone. RN-E stated she had deleted the pictures after she'd shown them to the DON. RN-E stated at the time she did not see any concerns with staff taking pictures of R1's wound however, said she now understood the concern for R1's right to privacy with medical treatment, and could see how the pictures could be undignified for the resident. RN-E stated she did not want pictures of R1's maggot-infested wound to be out there for people to see, did not think it would happen, but acknowledged it did. During an interview on 9/24/18 at 3:30 p.m., NA-F stated she heard RN-I ask LPN-H to show her a picture of the maggots. NA-F said LPN-H pulled up a picture on her phone and showed RN-I, and NA-F reported it to the DON the next time she saw her, two days later. When RN-I saw the picture, she talked with LPN-H about how horrible it was and how the maggots were between R1's toes. NA-F acknowledged the picture and sharing it was a privacy and dignity issue, and to have a nurse on her personal phone showing another nurse the picture was rude and degrading. NA-F stated LPN-H was not the nurse who originally took the pictures, and there was no reason for LPN-H to have the pictures or for RN-I to view them. NA-F stated she thought the pictures were absolutely against facility policy. When interviewed on 9/24/18 at 3:57 p.m., NA-G stated after RN-L discovered maggots on R1's foot wound, everything broke loose. NA-G stated LPN-B opened R1's wound dressing and showed staff, all the nurses and aides came to R1's room and viewed the maggots, and everyone was freaking out. NA-G thought she remembered a nurse using her personal phone to take a picture of R1's infested wound. NA-G stated she did not agree with taking pictures and knew it was against the facility's policy, and staff was not to have their phones out during their shift. NA-G described the picture taking as a privacy issue for R1. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/25/18 at 11:35 a.m., LPN-H stated RN-E asked her to request RN-L send the pictures to LPN-H's phone. LPN-H requested the pictures, and RN-L immediately sent them via a social media application. LPN-H admitted having the pictures, close-ups of maggots, on her personal phone and showing them to RN-E. LPN-H also showed the pictures to RN-I a week later, and stated she deleted the pictures after that. LPN-H stated she was aware taking pictures of residents is unacceptable, and said she had a sense the facility's policy did not allow it. LPN-H stated she did not think twice about the pictures when she received them because they did not show a face or name and were not tied to a person, and because she knew a nurse manager had asked for them. LPN-H confirmed the having the pictures and sharing them, violated R1's right to privacy and was undignified for the resident. When interviewed on 9/25/18 at 2:04 p.m., RN-I stated LPN-H offered to show her a picture of R1's wound and she agreed. RN-I stated it was not acceptable to take pictures of residents and their medical conditions and it was against the facility's policy. RN-I stated she would want written consent before taking a picture of a resident, and the pictures violated R1's rights to dignity and privacy. During an interview on 9/28/18 at 9:20 a.m., RN-L stated RN-E asked her to take a picture of R1's maggot-infested wound and send it to RN-E. RN-L stated she gave her phone to an aide, and LPN-B went with the aide, to take the pictures. RN-L stated she sent the pictures to RN-E and then deleted them from her phone's picture album. RN-L said the next day, RN-E asked LPN-H to ask RN-L to send a clearer picture to LPN-H. RN-L recalled LPN-B had used RN-L's phone to send pictures of R1's wound to her own personal phone, via a social media application. RN-L stated she found the pictures on the social media application, forwarded them to her phone's picture album, sent the pictures to LPN-H, and deleted them again. RN-L stated she would never use the social media application to send the pictures because it is a public website and a confidentiality thing. RN-L stated the facility's policy is staff cannot have their phones out during work hours, and they cannot take pictures of residents however, said RN-E asked her to take pictures and she did. RN-L stated the photos were a privacy and dignity issue for R1, and although a staff person verbally asked R1 for consent, it required written consent from the resident and/or the resident's representative. RN-L stated she knew that LPN-B, RN-E, LPN-H, RN-I, and herself saw pictures of R1's maggot-infested wound. The facility policy Resident Dignity, dated February 2013, was reviewed and included: The location will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The policy included ideas for maintaining a resident's dignity including, Refraining from taking unauthorized photographs or recordings of residents in any state of dress or undress using any type of equipment, e.g., cameras, smart phones and other electronic devices, and/or keeping or distributing unauthorized photographs or recordings of residents through multimedia messages or on social media networks. The facility policy Social Networking, dated February 2013, was reviewed and included: Before sharing a comment, post, picture or video about a friend or colleague through any type of online social media, it is a best practice to be courteous and first obtain his or her consent. Consent, however, is only part of it, as users also should consider how that comment, post, picture or video will affect the individual and others who view it. It is inappropriate to disclose personal information about another individual. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regarding cell phone camera use the facility's employee handbook, dated January 2014, included: Using cell phones with camera capabilities, cameras, video recorders or similar devices as it relates to resident, client and employee privacy, trade secrets and other business information. These devices are specifically prohibited from taking pictures or recording of audio or video in bathrooms, resident/client care areas and other areas containing confidential information including, but not limited to, employee, client and resident files, financial records and other proprietary Society documents. Regarding text messages, the facility's employee handbook indicated; Sending information classified as sensitive or confidential such as electronic protected health information via text messages is prohibited. Text messages are unsecured and can be intercepted during transit. In addition, protected health information would then be stored on any cell phone that sent or received the text message. Regarding social networking sites, the facility's employee handbook indicated; Posting residents'/clients' pictures and/or protected health information to a social networking site is strictly prohibited and will result in corrective action, up to and including termination. Regarding use of health information, the facility's employee handbook indicated, Any use or disclosure of resident/client health or financial information as defined by the HIPAA Privacy Rule must be authorized using Authorization to Use or Disclose Health Information (GSS #257). If disclosing or using a video or picture of a resident or client, Authorization for Media Disclosure (GSS #254) must be used.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to document wound assessments and care according to accepted standards of professional clinical practice for 2 of 4 residents (R1, R2), reviewed for charting of treatments. Staff charted wound assessments and wound treatments for R1 and R2 without completing them. Findings include: R1's quarterly review assessment dated [DATE], indicated R1 was cognitively intact; however, R1 had early dementia. R1's care plan dated 8/8/18, indicated R1 had blisters on the top of her left foot. The blisters resulted from fractures in her left foot. R1's face sheet, dated 9/6/18, indicated R1 had [DIAGNOSES REDACTED]. R1 was receiving monthly [MEDICAL CONDITION] for a skin [MEDICAL CONDITION] and was immunosuppressed. R1's Physician order [REDACTED]. Registered Nurse (RN)-J documented a wound data collection (WDC) for R1 on 7/29/18 at 9:58 a.m., but signed the WDC on 7/31/18. The WDC indicated RN-J had assessed and measured R1's wound, and RN-J charted various characteristics of R1's wound. Licensed Practical Nurse (LPN)-A documented a WDC for R1 on 7/30/18 at 5:22 p.m., which indicated LPN-A had assessed R1's wound and changed the dressing. R1's treatment administration record (TAR) for July indicated, Xeroform dressing daily to upper left foot with 4 x 4s and [MEDICATION NAME] wrap x 2 weeks. RN-J documented completing R1's dressing change on the TAR for 7/29/18, and LPN-A documented having completed R1's dressing change on the TAR for 7/30/18. On 7/31/18, LPN-B created an incident report for R1 noting, When changing AM (morning) dressing on 7-31-18 it was noted that the dressing was dated 7-28-18. An investigation report signed by several staff on 8/2/18 indicated; Dressing was changed on 7-28-18, and Staff reported this dressing was still on. Narrative comments indicated, Re-education to Nurses taking care of Elder these 2 days - Staff had documented they had measured. LPN-A documented WDC's for R1 on 8/3/18 at 2:33 p.m., and 8/4/18 at 2:11 p.m. The WDC's indicated LPN-A had assessed R1's wound and changed the dressing on those two days. R1's TAR for August 2018 indicated, Xeroform dressing daily to upper left foot with 4 x 4s and [MEDICATION NAME] wrap one time a day. LPN-A had also documented on the TAR completion of R1's dressing changes on 8/3 and 8/4/18. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/4/18, RN-L created an incident report for R1 noting, This nurse was notified by the aide that dressing on elder's left foot looks icky and that elder stated that her foot feels twitchy, however she denied pain when asked. And when this nurse opened the dressing to change it, there were so many maggots on the wound. The dressing was last changed on 8-2-18. The dressing is supposed to be changed daily in the morning. 'It feels twitchy and stingy.' An investigation report signed by several staff on 8/13/18 indicated, Elder was c/o foot twitching staff went to look at wound and noticed the date was from 8-2-18. Narrative comments indicated, Nurse that did not change dressing was put on suspension pending investigation. Elder was admitted to (local hospital) for further care + tx. R2's significant change assessment dated [DATE] indicated R2 was cognitively intact. R2's Physician order [REDACTED]. Keep clean/dry/covered until resolved. One time a day, Keep clean/dry/covered until resolved. R2's Physician order [REDACTED]. R2's face sheet dated 9/6/18, indicated R2 had [DIAGNOSES REDACTED]. LPN-A did not complete a WDC for R2 on 8/3/18, even though R1 required a daily dressing change per the physician's orders [REDACTED].>R2's TAR for 8/3/18 indicated: [MEDICATION NAME] (a type of wound dressing) with absorbent pad to abscess on left midback. Keep clean/dry/covered until resolved. One time a day. Keep clean/dry/covered until resolved. LPN-A documented completing R2's dressing change on the TAR for 8/3/18. On 8/3/18, LPN-H created an incident report for R2 which indicated: Noted that dressing was dated 8-2-18. Removed dressing, area around abscess site bright red with excessive drainage and continuing to drain. Elder complaining that area on her left upper side was itching. 'My abscess area itches.' LPN-A documented a WDC for R2 on 8/4/18 at 2:38 p.m. The WDC indicated LPN-A had assessed R2's abscess and changed the dressing. The note indicated the abscess had purulent drainage including, Drainage has foul smell. R2's TAR for 8/4/18 indicated,[MEDICATION NAME] island change dressing BID to left upper back abscess two times a day. LPN-A documented completing R2's morning dressing change on the TAR for 8/4/18. An Investigation Report signed by several staff on 8/13/18 indicated: dressing was not changed times 2 days it was signed off in the computer that it had been changed. Narrative comments indicated: Staff was re-educated on signing off on tasks that were not completed. In a written communication on 10/8/18, the interim DON indicated the incident report documented for R2 on 8/3/18, covered both 8/3 and 8/4/18 when LPN-A had charted but not completed wound cares for R2. During an interview on 9/6/18 at 1:54 p.m., LPN-A stated she charted two daily wound treatments for R2, on 8/3 and 8/4/18 that she did not do. LPN-A stated she did not remember any other times she documented a wound treatment for [REDACTED]. LPN-A acknowledged that charting cares she had not completed was a violation of facility policy, and stated she'd received corrective action for it. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 9/7/18 at 9:46 a.m., the DON stated during an investigation she'd discovered LPN-A had not completed R2's dressing change on 8/3 and 8/4/18. The DON stated LPN-A had charted the dressing changes on R2's TAR and completed WDC's those two days. The DON said LPN-A had told her she intended to complete R2's dressing changes so had charted them, and then became sidetracked and did not tell the next shift's nurses she did not do them. The DON stated she was aware of another incident on 7/31/18 where LPN-B discovered R1's dressing was still dated 7/28/18. RN-J had charted a WDC and dressing change for R1 on 7/29/18, and LPN-A had charted having completed R1's dressing change for 7/30/18. The DON stated the facility teaches staff to chart only after they have completed a treatment, and acknowledged the incidents violated a standard of care. During an interview on 9/11/18 at 5:05 p.m., RN-E stated on 7/29 and 7/30/18, RN-J and LPN-A had charted dressing changes for R1 they did not complete. RN-E said LPN-A had also charted a dressing change for R2 on 8/3 and 8/4/18 which she had not completed. RN-E stated it is a standard of care to perform the care before charting it. When interviewed on 9/25/18 at 2:53 p.m., RN-J stated she may have inadvertently documented R1's dressing change on 7/29/18, but confirmed she did not complete the dressing change that day. RN-J agreed a standard of care was to provide a treatment prior to documenting it, and that doing otherwise was a violation of facility policy. During an interview on 9/28/18 at 9:20 a.m., RN-L stated some nurses chart they did something they did not do, even including wound measurements. RN-L stated she was aware LPN-A had documented completing dressing changes for R1 which she hadn't done, and said she thought LPN-A had also charted completion of two dressing changes for R2 which she hadn't done. RN-L stated it was a standard of care to provide a treatment prior to documenting it, and that doing otherwise was a violation of facility policy. During an interview on 10/2/18 at 3:01 p.m., family member (FM)-M stated the DON informed R1's son that the nurse who had not completed the dressing changes had later returned to R1's chart and documented the treatments. The facility's policy Documentation, dated September 2012, included: All documentation is expected to be legible, accurate, understandable, timely and pertinent and held in confidence. Documentation is NOT to be altered or falsified. Examples include, but are not limited to, backdating and /or altering data to secure more favorable rates. Backdating may be defined as dating any document prior to completing the required information or dating it a different date than the actual entry date. The policy also included: The director of health information management or other health information management personnel, quality and the nursing department will be responsible for monitoring documentation. In the absence of health information management personnel, the nursing department will have this responsibility. The facility's procedural policy for Wound Dressing Changes and the clinical skill checklist, both dated October 2017, indicate to chart dressing changes and wound observations after performing the treatment.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, residents preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide wound assessments and prescribed wound treatments for 2 of 4 residents (R1, R2), reviewed for treatment and care per physician orders. Staff did not notify the medical provider when they noted part of R1's wound had green drainage or when the wound developed a pungent odor. R1 experienced actual harm when staff discovered she had a maggot-infested foot wound, which necessitated emergent transfer to the emergency department (ED) and a three-day hospital admission to treat. A hospital physician diagnosed R1 with wound [MEDICAL CONDITION]. Findings include: R1's quarterly minimum data set (MDS) assessment dated [DATE], indicated R1 was cognitively intact; however, R1 had early dementia. The MDS also indicated R1 required assistance of one staff person for most activities of daily living. R1's care plan dated 8/8/18, indicated R1 had blisters on the top of her left foot which had occurred following left foot fractures. R1's face sheet dated 9/6/18, indicated R1 had [DIAGNOSES REDACTED]. R1 was receiving monthly [MEDICAL CONDITION] for a skin [MEDICAL CONDITION] and was immunosuppressed. R1's physician order [REDACTED]. Record review indicated the following: Registered Nurse (RN)-J documented a wound data collection (WDC) for R1 on 7/29/18 at 9:58 a.m., but signed the WDC on 7/31/18. The WDC indicated RN-J had assessed and measured R1's wound, and RN-J charted various characteristics of R1's wound. Licensed Practical Nurse (LPN)-A documented a WDC for R1 on 7/30/18 at 5:22 p.m., which indicated LPN-A had assessed R1's wound and changed the dressing. R1's treatment administration record (TAR) for July indicated, Xeroform dressing daily to upper left foot with 4 x 4's and [MEDICATION NAME] wrap x 2 weeks. RN-J documented completing R1's dressing change on the TAR for 7/29/18, and LPN-A documented having completed R1's dressing change on the TAR for 7/30/18. On 7/31/18, LPN-B created an incident report for R1 noting, When changing AM (morning) dressing on 7-31-18 it was noted that the dressing was dated 7-28-18. An investigation report signed by several staff on 8/2/18 indicated; Dressing was changed on 7-28-18, and Staff reported this dressing was still on. Narrative comments indicated, Re-education to Nurses taking care of Elder these 2 days - Staff had documented they had measured. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	LPN-A documented WDCs for R1 on 8/3/18 at 2:33 p.m., and 8/4/18 at 2:11 p.m. The WDC's indicated LPN-A had assessed R1's wound and changed the dressing on those two days. R1's TAR for August 2018 indicated, Xeroform dressing daily to upper left foot with 4 x 4's and [MEDICATION NAME] wrap one time a day. LPN-A had also documented on the TAR completion of R1's dressing changes on 8/3 and 8/4/18. Review of WDC's for R1's foot wound from 7/7/18 - 8/4/18, indicated staff had not documented the wound bed characteristics. In addition, staff had omitted documenting other wound characteristics, such as the margins and condition of the tissue surrounding the dressing. However, the WDC for 7/31/18, indicated R1's wound had green drainage on the wound dressing and leaking around it. The WDC for 8/1/18, also indicated R1's wound had green drainage. The WDC for 8/2/18, indicated R1's wound had a a slight odor, and the skin from the popped blister was loose with the skin beneath being beefy red. The 8/2/18 note further indicated there was drainage on the dressing covering the wound. There was no indication staff had contacted R1's physician regarding any concerns with the wound's odor or drainage. On 8/4/18, registered nurse (RN)-L created an incident report for R1 noting, This nurse was notified by the aide that dressing on elder's left foot looks icky and that elder stated that her foot feels twitchy, however she denied pain when asked. And when this nurse opened the dressing to change it, there were so many maggots on the wound. The dressing was last changed on 8/2/18. The dressing is supposed to be changed daily in the morning. 'It feels twitchy and stingy.' A progress noted from 8/4/18 at 8:06 p.m., indicated staff had called 911 and emergently transferred R1 to the local hospital due to a concerns with her wound. R1's hospital records from 8/4/18, indicated R1 presented to the emergency department (ED) on 8/4/18 with complaint of a left foot wound infection and maggots in the wound. The notes indicated when R1 arrived, her left foot was in a plastic bag. Hospital staff removed the bag and soaked R1's foot for 40 minutes in a mixture of solutions that killed the maggots, then removed dead skin from the wound. The ED physician noted R1's left foot was puffy and red from the midfoot down, with maggots coating the front and back of her third toe. The physician documented he did not feel the dressing changes had not been done regularly, and now maggots were in the wound. The physician notes also indicated some blistering of the open wound, so R1 was admitted to the hospital for aggressive wound care and intravenous (IV) antibiotic therapy. The physician noted, Patient is a high risk individual given the fact that she is currently on [MEDICAL CONDITION] so she is immunosuppressed and given her underlying doses (diagnosis) of [MEDICAL CONDITION], is simply not able to take care of herself. R1's additional hospital [DIAGNOSES REDACTED]. A hospital physician's progress note from 8/5/18 at 6:26 p.m., indicated R1 continued to express concern about her left foot having maggots, and described her foot as swollen, red, tender, and had purulent discharge. Hospital records dated 8/7/18, indicated R1 discharged from the hospital and returned to the nursing home with specific instructions for wound care to her left foot and a prescription for oral antibiotics. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The facility's investigation report signed by several staff on 8/13/18 indicated, Elder was c/o foot twitching staff went to look at wound and noticed the date was from 8-2-18. Narrative comments indicated, Nurse that did not change dressing was put on suspension pending investigation. Elder was admitted to (local hospital) for further care + tx. R2's significant change assessment dated [DATE] indicated R2 was cognitively intact. R2's physician order [REDACTED]. Keep clean/dry/covered until resolved. one time a day Keep clean/dry/covered until resolved. R2's Physician order [REDACTED]. R2's face sheet dated 9/6/18, indicated R2 had [DIAGNOSES REDACTED]. LPN-A did not complete a WDC for R2 on 8/3/18, even though R1 required a daily dressing change per the physician's orders [REDACTED].>R2's TAR for 8/3/18 indicated: [MEDICATION NAME] (a type of wound dressing) with absorbent pad to abscess on left midback. Keep clean/dry/covered until resolved. One time a day. Keep clean/dry/covered until resolved. LPN-A documented completing R2's dressing change on the TAR for 8/3/18. On 8/3/18, LPN-H created an incident report for R2 which indicated: Noted that dressing was dated 8-2-18. Removed dressing, area around abscess site bright red with excessive drainage and continuing to drain. Elder complaining that area on her left upper side was itching. 'My abscess area itches.' LPN-A documented a WDC for R2 on 8/4/18 at 2:38 p.m. The WDC indicated LPN-A had assessed R2's abscess and changed the dressing. The note indicated the abscess had purulent drainage including, Drainage has foul smell. R2's TAR for 8/4/18 indicated,[MEDICATION NAME] island change dressing BID to left upper back abscess two times a day. LPN-A documented completing R2's morning dressing change on the TAR for 8/4/18. An Investigation Report signed by several staff on 8/13/18 indicated: dressing was not changed times 2 days it was signed off in the computer that it had been changed. Narrative comments indicated: Staff was re-educated on signing off on tasks that were not completed. In a written communication on 10/8/18, the interim DON indicated the incident report documented for R2 on 8/3/18, covered both 8/3 and 8/4/18 when LPN-A had charted but not completed wound cares for R2. During an interview with R2 on 9/6/18 at 12:10 p.m., R2 stated she had an infected cyst on her left back, and a nurse noted the dressing needed to be changed. R2 stated after that, the same nurse checked her dressing every night to make sure it was completed. R2 stated she thought LPN-A was the nurse who hadn't done the dressing change. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	When interviewed on 9/6/18 at 12:57 p.m., R1 stated she'd felt movement on her left foot by her toes for one or two days before staff discovered the maggots. R1 stated there was always blood showing on her foot, and didn't feel staff properly checked or cleaned her wound, so the maggots were unfortunately being fed very well. R1 stated she was not very happy about the situation. During the interview, R1 shook her head and made noises indicating disgust multiple times. R1 stated the maggots were very gross, should never have happened, and stated staff were not always changing her wound dressings daily at the time maggots were discovered. R1 also stated she was frequently outside, did not wear a sock, but always wore her boot. R1 said she did not refuse dressing changes by staff. Observations of R1's foot indicated her wound had healed. During an interview on 9/6/18 at 1:54 p.m., LPN-A stated she charted two daily wound treatments for R2, on 8/3 and 8/4/18 that she did not do. LPN-A stated she did not remember any other times she documented a wound treatment for [REDACTED]. LPN-A acknowledged that charting cares she had not completed was a violation of facility policy, and stated she'd received corrective action for it. LPN-A stated staff are supposed to document all of the wound's characteristics on the daily WDC. LPN-A verified R1 did not refuse dressing changes. When interviewed on 9/6/18 at 4:34 p.m., LPN-B stated she created an incident report for R1 on 7/3/18, when she went to do a dressing change and saw the wound dressing was dated 7/28/18. LPN-B said staff were supposed to change R1's left foot wound dressing daily in the morning. LPN-B stated RN-J had not changed R1's dressing on July 29, and LPN-A had not changed the dressing on July 30. LPN-B said on 7/31/18, one of R1's wound blisters had a green tint, and LPN-B stated she had RN-E assess R1's wound when she did the dressing change, to note the green drainage in the blister. LPN-B described R1's wound dressing as consisting of gauze pads wrapped by gauze bandage rolls. LPN-B stated at the start of her evening shift on 8/4/18, LPN-A had reported R1 was complaining of her foot tingling. LPN-B further stated R1 had received Tylenol that evening, and the evening shift aides had reported the top of R1's wound dressing was dark brown and hard. Upon visual review, RN-L had discovered maggots on R1's wound but could not stomach it, so she had requested LPN-B come to help. LPN-B stated there were hundreds of maggots piled on R1's wound, at least four deep at a minimum, across the entire wound on R1's foot by her toes. LPN-B said at that time, the dressing on R1's wound was dated 8/2/18. LPN-B said she considered the previous observation of green fluid an abnormal finding, but wasn't sure why staff had not escalated that concern. LPN-B stated when she saw the maggots, R1's wound had a foul, spoiled food smell. In addition, she said there was baseball-sized, dark-brown and hard drainage soiling the dressing on top of R1's wound, and all of the gauze layers of the dressing were stuck together. LPN-B stated staff had not been completing wound care per the physician order, and said if they had they done so, the infection may have been avoided and staff could have prevented the extent of the maggot-infestation. LPN-B said when she'd seen R1's wound on 8/1/18 it appeared to be drying up however, on 8/4/18 when she saw the maggots, the wound had appeared wet, macerated, and raw red with pinpoints where the maggots were eating tissue. LPN-B said there was also some blood at the surface of the wound. LPN-B said when she'd spoken with the resident, R1 became teary-eyed, covered her face with a sweater, asked why?, stating it's gross multiple times. LPN-B also said R1 had expressed being upset she had to transfer to the hospital and wanted the facility to pay for it. After R1 learned maggots were on her wound, she squirmed around and appeared uncomfortable, and asked LPN-B to get the maggots off her. LPN-B said she'd covered R1's foot with a garbage bag before R1 was transferred to the hospital. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview with the director of nursing (DON) on 9/7/18 at 9:46 a.m., the DON stated she'd discovered during an investigation LPN-A had not completed R1's dressing change on 8/3 or 8/4/18. The DON stated LPN-A had charted the dressing changes on R1's TAR and completed WDC's for both of those days. The DON said when she'd spoken with LPN-A, LPN-A had told her she'd intended to complete R1's dressing changes, charted them, and then became sidetracked and did not tell the next shift's nurses she had not done them. The DON stated she was aware of another incident on 7/31/18 where LPN-B had discovered R1's dressing was still dated 7/28/18 even though RN-J had charted a WDC and had documented having completed the dressing change for R1 on 7/29/18. The DON verified LPN-A had also charted R1's dressing change as completed 7/30/18. The DON stated the facility teaches staff to chart only after they complete a treatment, and acknowledged the incidents violated a standard of care. The DON verified staff had not completed R1 and R2's wound care per their physician orders. The DON also said once the staff had discovered the maggots on R1's wound, the facility had directed nurse managers to check the status of all resident wounds and dressings in the building, and they had not found any other concerns. The DON stated she thought there was some confusion among staff about charting WDC's, and ideally staff would complete all parts of the form. The DON said the facility had previously held a skills fair for the nurses in May 2018, and at that time had provided education and hands-on practice with wound assessment, documentation, and dressing changes. The DON said the wound infestation likely occurred because staff did not change R1's dressing, a fly laid eggs, and the dressing might not have been secure due to not having been changed. The DON stated, it's fair to say the lack of dressing change for two days did not help matters. When interviewed on 9/7/18 at 12:24 p.m., emergency medical technician (EMT)-D stated when she had arrived at the facility on 8/4/18, staff had reported to her R1's wound dressing was supposed to be changed daily. EMT-D said staff told her it looked like staff had not changed R1's dressing for a couple days, and since that time R1's foot had become infected with maggots. EMT-D stated R1 had MS and needed help to perform normal functions of daily life, and had not received help with her dressing change. EMT-D stated she had seen the maggots and part of R1's wound through the plastic bag around her foot, and stated it appeared maggots were eating at the base of R1's foot and in between her toes. During an interview on 9/11/18 at 5:05 p.m., RN-E stated on 7/29 and 7/30/18, RN-J and LPN-A had charted dressing changes for R1 they did not complete. RN-E said LPN-A had also charted a dressing change for R2 on 8/3 and 8/4/18 which she had not completed. RN-E stated it is a standard of care to perform the care before charting it. RN-E stated she thought green drainage would be something to address and inform the provider about, but said she had not observed that. RN-E thought staff sometimes completed only parts of the WDC's, and staff struggled with charting what the wound base looks like, wound margins, and what they perceive a wound looks like compared to someone else. RN-E's stated it was her understanding that staff should chart on or address all sections of the WDC's. RN-E said it made sense to her that when staff failed to change R1's dressing for two days, it increased the likelihood a fly would find it. When interviewed on 9/24/18 at 3:57 p.m., NA-G stated the day of the incident (9/4/18) R1 had been complaining of pain in her foot and did not want to go to dinner, which was unusual. NA-G said she'd noticed dark-brown drainage leaking out of R1's wound dressing and had informed the nurse. NA-G said R1 had complained her wound was tingly and numb. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/25/18 at 11:35 a.m., LPN-H stated on on 8/2/18 when she'd observed the wound, she had thought it was healing. She said she'd had the RN come down and look at the wound with her. She said it there had been no green drainage at that time, just a small to moderate amount of yellow drainage. LPN-H said she would describe the odor she'd noted at that time as dirty feet, not like a wound smell. LPN-H stated if she'd seen green drainage or an unusual wound odor she would have considered it to be abnormal. When interviewed on 9/25/18 at 2:53 p.m., RN-J stated she may have inadvertently documented R1's dressing change on 7/29/18, but confirmed she did not complete the dressing change that day. RN-J agreed a standard of care was to provide a treatment prior to documenting it, and that doing otherwise was a violation of facility policy. RN-J stated when completing WDC's, she was not that comfortable documenting certain wound characteristics such as wound margins, eschar, and sloughing. During an interview on 9/28/18 at 9:20 a.m., RN-L stated on 8/4/18 NA-G had come to report that R1's dressing looked gross and soaked. RN-L stated the dressing was actually dry and rock hard from wound drainage that nearly covered the entire dressing. The date on R1's dressing indicated staff had changed it two days prior (8/2/18). RN-L said R1 had reported her foot felt squishy and wiggly. RN-L said she cut the dressing open and discovered maggots on R1's foot wound. RN-L said she'd felt faint and contacted LPN-B for help. RN-L said when she checked the computer she'd noticed LPN-A had charted dressing changes the past two days,which had not actually been done. RN-L stated staff were supposed to complete all sections of WDC's except for measurements, which they do twice per week. RN-L stated it was a standard of care to provide a treatment prior to documenting it, and that doing otherwise was a violation of facility policy. During an interview on 10/2/18 at 3:01 p.m., family member (FM)-M stated on 8/4/18 a nurse had called to inform her R1 was at the emergency department due to maggots in her wound. FM-M stated the maggots were quite large, there was noted redness and swelling at the base of R1's toes and the top of her foot, and R1 was admitted to the hospital. FM-M stated the DON had informed R1's son that the nurse who had not completed the dressing changes had later returned to R1's chart and documented the treatments. FM-M said a hospital physician had diagnosed R1 with [MEDICAL CONDITION] and prescribed IV antibiotics. FM-M stated R1 was incapable of saying her wound dressing was gross and needed to be changed. The facility's policy Documentation, dated September 2012, included: All documentation is expected to be legible, accurate, understandable, timely and pertinent and held in confidence. Documentation is NOT to be altered or falsified. Examples include, but are not limited to, backdating and /or altering data to secure more favorable rates. Backdating may be defined as dating any document prior to completing the required information or dating it a different date than the actual entry date. The policy also included: The director of health information management or other health information management personnel, quality and the nursing department will be responsible for monitoring documentation. In the absence of health information management personnel, the nursing department will have this responsibility. The facility's September 2017 policy, Abuse Definitions, included: NEGLECT: Failure of the location, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The facility's procedural policy for wound dressing changes and the clinical skill checklist, both dated October 2017, indicated to chart dressing changes and wound observations after performing the treatment. The facility's June 2018 policy, Abuse and Neglect, included: The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation.